IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

February 1, 2007

Geraldine Stanfield, Administrator
Summer Wind, A Retirement & Assisted Living Community
5955 Castle Dr
Boise, ID 83703

Dear Ms. Stanfield:

On January 5, 2007, a complaint investigation survey was conducted at Summer Wind, A Retirement & Assisted Living Community. The survey was conducted by Debra Sholley, LSW and Rebecca Winter, RN. This report outlines the findings of our investigation.

Complaint # ID00001972

Allegation #1: Complainant states safeguards were not in place to assist the resident with transferring and ambulation and they were not being used consistently by staff. Additionally, emergency services were not obtained in a timely manner.

Findings: Based on interview and record review it could not be determined the facility did not provide assistance with transferring and seek emergency services in a timely manner.

Review of an "Event Report" dated September 22, 2006 at 7:00 a.m. documented staff entered the resident's room and saw the resident on the floor in the bathroom on her right side with her head between the wall and toilet and her legs outstretched toward the sink. "Paramedics arrived and got resident onto stretcher She had a skin tear to her right shoulder and forearm and bruising and swelling to middle finger of right hand. Res (Resident) c/o (complained of) shoulder and hip pain." It was documented the family was notified on September 22, 2006 at 7:30 a.m. and the physician was notified on the same day at 9:00 a.m.

Review of progress notes dated September 22, 2006 revealed documentation that when staff found the resident on her bathroom floor the nurse instructed the caregivers to call 911.

On January 5, 2007 at 4:00 p.m. the administrator and the licensed nurse stated their investigation revealed there were approximately 15 minutes between the last resident check and when she was found on her bathroom floor. They stated the resident was on 2 hour checks, and used a pressure pad alarm. Additionally, they stated the resident was "annoyed" by the sound of the alarm and would unhook it. "She was embarrassed that she needed the alarm, and often times she would forget to call for assistance."

On January 5, 2007 at 3:45 p.m. a caregiver stated they had been checking on the resident more frequently than every 2 hours due to the increase of falls.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation conducted on January 5, 2007. The facility was offering several assistive devices to help the resident's mobility and safety, and staff utilized them appropriately. However, the resident was resistant to their use and was embarrassed by them. Emergency services were obtained immediately after the resident fell.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Debbie Sholley, LSW

DEBBIE SHOLLEY, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

FILE COPY

February 1, 2007

Geraldine Stanfield, Administrator
Summer Wind, A Retirement & Assisted Living Community
5955 Castle Dr
Boise, ID 83703

Dear Ms. Stanfield:

On January 5, 2007, a complaint investigation survey was conducted at Summer Wind, A Retirement & Assisted Living Community. The survey was conducted by Debra Sholley, LSW and Rebecca Winter, RN. This report outlines the findings of our investigation.

Complaint # ID00002179

Allegation #1: Resident medications have been missed, for example ear drops.

Findings: Based on interview and record review it was determined the identified resident received ear drops as ordered.

Review of the identified resident's record revealed a physician's order dated October 26, 2006 for "Debrox ear drops OTC (over the counter) PRN (as needed)."

Review of the October and November 2006 medication assistance records revealed the resident received ear drops on October 28, 2006, November 1, 2006 and November 2, 2006.

On January 5, 2007 at 2:30 p.m., a caregiver stated residents could certainly have their PRN (as needed) medications when they asked for them.

On January 5, 2007 at 4:00 p.m., the administrator confirmed the residents would receive PRN medications when requested.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

Allegation #2: The resident is left dirty for long periods of time The identified resident goes without a bath for over a week and is incontinent of urine. Staff only changes her bedding every 2 weeks, also they are not emptying the resident's trash receptacle often enough and the urine soaked pads are left in the trash causing her room to smell of strong urine odor.

Findings: Based on observation, interview and record review it was determined the identified resident was assisted with hygiene, bed changes and house keeping.

Review of the identified resident's record revealed a combined UAI/NSA (Uniform Assessment Instrument/Negotiated Service Agreement) dated November 22, 2006, which documented in the "Toileting" section the identified resident was to receive assistance with toileting as needed and the resident was able to notify staff when the need for toileting arose. In the section entitled "Personal Hygiene" the UAI/NSA it was documented the identified resident would receive a shower two times a week, and the resident was able to wash most of the body. In the section entitled "Laundry" the UAI/NSA it was documented the identified resident would have bed linens changed weekly on Monday. In the section entitled "Housework" the UAI/NSA it was documented the caregivers would assist the identified resident with emptying trash every day and keeping the room tidy.

On January 5, 2007 at 10:50 a.m. the identified resident was observed and interviewed. There were no odors of urine in the resident's room. The resident stated she tended to clutter her room and the caregivers kept it clean for her. The resident stated she knew how to use the call system and could call the caregivers if she needed assistance with toileting, or if her trash needed to be emptied.

On January 5, 2007 at 2:00 p.m. the licensed nurse stated the identified resident's days for bathing were Sunday and Wednesday, and that they had been assisting the resident with bathing on those days.

On January 5, 2007 at 3:40 p.m., the administrator stated they were following the UAI/NSA in the cares of the identified resident. Further, she was aware of the potential for odors of urine to build up in the resident's room as the resident was incontinent at times and used attends, so she had caregivers empty the trash in the identified resident's room every shift.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

Allegation #3: There are not enough staff to meet residents needs.

Findings: Based on observation, interview and record review it was determined there was enough staff to meet he needs of the residents.

Review of the staffing schedule on January 5, 2007 revealed there were three caregivers scheduled to work from 6 a.m. through 10 p.m. each day, and two caregivers from 10 p.m. through 6 a.m. each night.

On January 5, 2007 review of four sampled residents revealed the needs and care outlined in the combined UAI/NSA was consistent and congruent with the care needs observed in the residents at the time of the survey. It was also observed the care was being provided as outlined in the UAI/NSA.

On January 5, 2007 the four sampled residents stated their needs were being well met.

On January 5, 2007 at 10:20 a.m., the administrator confirmed the facility was staffed as outlined above. Plus, during the daytime there were others scheduled, such as the licensed nurse and the activities person.

On January 5, 2007, during a tour of the facility, ten random residents stated their needs were well met at the facility. For example one stated, "They are wonderful." Another stated, "They help us with whatever we need."

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

Allegation #4: A dog is allowed in the dinning room during meals.

Findings: Based on observation and interview it was determined the facility did not allow dogs in the dining room.

On January 5, 2007 at 10:15 a.m., no dogs were observed in the dining room.

On January 5, 2007 at 12:30 p.m., during the lunch serving time, no dogs were observed in the dining room.

On January 5, 2007 at 10:30 a.m., the administrator stated animals were not allowed in any of the common areas, including the dining room. Further, she stated there was only one pet residing in the facility at the time and it was a cat.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

Allegation #5: Caregivers are new and not able to answer questions on what to do in case of a fire or disaster plan.

Findings: Based on interview and record review it was determined staff were oriented about

fire and disaster plans, and staff could answer questions about the plans.

Review of the form entitled "Employee Onboarding Checklist" on January 5, 2007 revealed the topic of "emergency preparedness," which included fire plans and procedures, fire drills, emergency plans and evacuation.

On January 5, 2007 at 2:30 p.m., the licensed nurse stated the "Employee Onboarding Checklist" was used for orientation of all new staff members. The nurse also was able to describe the fire and disaster plans, which included moving residents away from the fire and through the fire doors or the many exterior doors. Further, the nurse stated all of the caregivers had walkie-talkies with them at all times, so they could communicate with one another during any such disaster event.

On January 5, 2007 at 3:00 p.m. a caregiver was also able to describe the facility's plan for fire and disaster.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

Allegation #6: New caregivers do not assist the residents with their medication in a timely manner. Residents are lined up for approximately 45 minutes before receiving medications.

Findings: Based on observation and interview residents were assisted with medications in a timely manner.

On January 5, 2007 the administrator stated the residents who were able had always come to the "nurse station" for their medications. The residents who were unable to come to the nurse station were assisted with their medications in their rooms. She stated she had researched this process when she first was in the facility as the administrator. The outcome of her research was the residents wanted to keep the process as it was.

On January 5, 2007 at 10:30 a.m., an instance of medication assistance was observed when a resident came to the "nurse station" for potassium and pain medications. The caregiver was immediately available and helpful to the resident.

On January 5, 2007 at 11:30 p.m., medication assistance at the "nurse station" was observed. Several residents arrived one after the other to be helped with their medications. No resident waited longer then 1 to 3 minutes before being assisted with medications. No long line was observed forming for the same purpose.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

Allegation #7: The new administrator has been very rude when approached with complaints.

Findings: Based on observation and interview it was determined the administrator was not perceived as being rude.

On January 5, 2007 the administrator was observed and interviewed in relation to the complaint investigation. She presented as being polite and helpful during the entire process.

On January 5, 2007, during a tour of the facility, ten random residents stated the administrator was polite and approachable.

On January 5, 2007 at 2:30 p.m., the licensed nurse felt the administrator was polite, even when she needed to be direct. The nurse said he had not heard any complaints the administrator was rude.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on January 5, 2007.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Debbie Sholley, LSW

DEBBIE SHOLLEY, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program